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NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

diabetes NEWSLETTER

University of Medicine and Dentistry of New Jersey ■ Published by UMDNJ-Center for Continuing Education

UMD NEW JERSEY

TABLE OF Contents

diabetes update

There are more than 10 million known persons with diabetes mellitus in the United States. Epidemiological surveys indicate that more than 5 million people remain unaware of their asymptomatic diabetes. This is as much an insidious risk factor for multiple complications as is known diabetes. Following the publication of the Diabetes Control and Complications Trial (DCCT) in 1993, a consensus emerged that correction of abnormal glucose metabolism will prevent and retard the development of diabetic complications. Identifying diabetic patients unaware of their diagnosis would therefore reduce the risk to themselves and the enormous burden on the health care system.

To address this issue, the American Diabetes Association named an Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. The Committee presented recommendations in Boston in June of 1997. The Committee's conclusions will have significant medical and economic implications. The national Centers for Disease Control and Prevention strongly recommends that the new diagnostic and classification criteria be adopted, promulgated, and implemented by all individuals and organizations that identify and care for people with diabetes. The new diagnostic criteria are based on sound scientific evidence. On balance, patients should benefit by having a greater opportunity to be diagnosed and to receive treatment before complications develop. Simultaneously, more data are necessary to validate and support the committee's recommendation to test all people 45 years and older every 3 years. The Committee redefined the critical glucose values for diagnosis of diabetes, developed guidelines for testing to reduce the risk of complications and reviewed the diagnosis of gestational diabetes. New nomenclature presented distinguishes patients with diabetes totally dependent on insulin for survival (type 1) from those who may use it in their metabolic regulating regimen but are not necessarily dependent upon it (type 2).

The baseline value of the fasting plasma glucose for the diagnosis of diabetes mellitus was reduced from 140 mg/dl to 126 mg/dl. This simple reduction will identify many more people shown to experience the accelerated atherosclerosis typical of diabetes mellitus. However, the value of 126 mg/dl or greater needs to be confirmed by repeat testing on a different day. The Committee recommended that the medical community begin testing for diabetes mellitus in all persons aged 45 or above at 3 year intervals as part of routine care.

EDITOR'S NOTE:

The recommendations from the Expert Committee were incorporated into the January, 1998 Standards of Care for the ADA. See *Diabetes Care*, Supplement, 1, Volume 21, 1998.

THESE HIGH RISK GROUPS WERE DEFINED AS PERSONS WITH:

1. obesity or weighing 20% above ideal weight;
2. first degree relatives with diabetes mellitus;
3. high risk ethnic groups (African, Hispanic, Native and Asian Americans);
4. prior diagnosis of gestational diabetes mellitus or delivering a baby weighing more than 9 lbs;
5. high blood pressure (greater than 140/90);
6. low HDL cholesterol (< than 35 mg/dl) or high triglycerides (>than 250 mg/dl); or
7. impaired fasting glucose (value>110 mg/dl but <126 mg/dl) or impaired glucose tolerance (2-hour value of glucose tolerance test >140 mg/dl, but <200 mg/dl). A 2-hour value greater than 200 mg/dl definitively diagnoses diabetes mellitus.

Testing should also be performed at younger ages in individuals considered to be in high risk groups for diabetes mellitus.

The existing glucose criteria for the diagnosis of gestational diabetes mellitus were retained. Again noting recent research, the Committee recommended that pregnant women younger than 25 years old and not in high risk groups need not be screened for gestational diabetes.

The essence of the Expert Committee report is to encourage the discovery of persons with mild diabetes mellitus so that education directed at lifestyle modification might prevent progression to overt diabetes with its often devastating medical, social and economic consequences.

(Louis Amorosa, MD, Professor of Clinical Medicine, UMDNJ-RWJMS) ■

diabetes mellitus & jackie robinson...

50 YEARS AGO

Last spring, President Clinton visited a school in Brooklyn and attended a baseball game in New York to honor Jackie Robinson. There were numerous other tributes throughout 1997 to celebrate the 50th anniversary of Robinson's breaking the color barrier in major league baseball. Following his retirement from baseball, Robinson began an active life-long campaign to address civil injustices in business and social affairs. This public crusade overshadowed his daily personal battle with diabetes mellitus which began soon after he gave up the daily physical conditioning of his athletic life. That battle was complicated by blindness in one of his eyes, ischemic pain of such intensity that he feared amputation, and recurrent bouts of heart failure. He died on October 24, 1972, at age 53. Twenty-five years since his death not only marks continued progress in the arena of social injustice, but also steady medical advances against diabetes mellitus and cardiovascular disease which now could have extended Robinson's life.

His onset of diabetes mellitus at age 38, associated with his own sedentary lifestyle and the fact that his two older brothers had previously developed the disorder, suggests that Robinson was a type 2 diabetic. However, the concept of type 2 diabetes mellitus with hyperinsulinemia was not defined until the publication of Yalow and Berson's Nobel prize work in 1959. Thus, Robinson was treated from the onset with insulin - two injections, rather than with oral drugs which often attenuates the hyperinsulinemia of early type 2 diabetes mellitus.

Jackie Robinson's diabetic eye disease resulted in bleeding within the eye. Though he received experimental treatment by laser, it was clearly too late, and he lost his vision in one eye. Elevated blood pressure probably contributed to his eye disease as well as his multiple heart attacks. By the mid 1970's, early laser therapy was proven to preserve diabetic vision. In 1976, publication of the multi center diabetic retinopathy trial demonstrated that conclusion.

A number of other studies published over the last 25 years definitively demonstrated that identification and treatment of cardiovascular risk factors in diabetes mellitus can prolong life. The treatment of hypertension in the early 1970's, discovered that reducing blood pressure lowered the risk of strokes and cerebral hemorrhages. Major trials in the 1980's demonstrated that treatments of left ventricular dysfunction with converting enzyme inhibitors prolong life. These drugs also limit proteinuria in diabetic nephropathy, thereby slowing its progression.

The Diabetes Control and Complications Trial published in 1993, demonstrated that values of hemoglobin A_1C below 8% were also associated with reduced proteinuria and progression of diabetic nephropathy. Recently, further analysis of the Scandinavian Simvastatin Survival Study (S4) and the Coronary and Recurrent Events (CARE) trial showed that reduction in cholesterol with statins reduced strokes as well as cardiac mortality in patients with diabetes mellitus. Thus, if hyperlipidemia cannot be controlled with treatment of diabetes, statin therapy appears justified.

With better understanding of the pathogenesis of type 2 diabetes mellitus, the first trial to prevent the disorder is now recruiting patients. The Diabetes Prevention Trial (DPT) is focusing on people with high risk factors: America's ethnic minorities, people with a strong family history and patients with impaired fasting glucose values (110-126 mg/dl). Considering his role in the quest for equal treatment of minority people, his family history of diabetes and his own diabetic saga, Jackie Robinson would have become the first patient to enroll.

(Louis Amorosa, MD, Professor of Clinical Medicine, UMDNJ-RWJMS). ■

author disclosure of commercial support

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satellite conference reaches statewide audience

On October 30, 1997, the Centers for Disease Control and Prevention presented a live, interactive satellite broadcast on diabetes. Through the cooperation of the New Jersey Department of Health and Senior Services, "Diabetes - Control is Prevention" was seen by viewers at ten sites across the state of New Jersey.

National sponsors included the National Diabetes Education Program, the Diabetes Council, the American Association of Diabetes Educators, the American Diabetes Association, the Indian Health Service, the American Public Health Association, the National Institute of Diabetes and Digestive and Kidney Diseases, the American Dietetic Association, and the Juvenile Diabetes Foundation International.

Locally, supporters included UMDNJ-RWJMS Center for Continuing Education, the New Jersey Diabetes Council, the Commission for the Blind and Visually Impaired, Garden State Association of Diabetes Educators, the New Jersey Chapter of the American Diabetes Association, Camp Nejeda, the Juvenile Diabetes Foundation, Joslin Center for Diabetes at St. Barnabas, Princeton Division, Veterans Administration Hospital, Ocean County Department of Health, Pascack Valley Hospital, Newton Memorial Hospital, St. Peters Medical Center, Dover General Hospital, Atlantic County Community College, New Jersey Network, and Camden County College.

The goals of the conference were to increase the awareness of the impact of diabetes, highlight existing efforts to reduce the burden of diabetes, and mobilize communities to action to improve diabetes outcomes.

The program looked at three dimensions of diabetes:

▲ A LIFE OF BALANCE

- ▲ What is the impact of diabetes on America?
- ▲ Why control diabetes?
- ▲ What care is needed to prevent complications?

▲ A COMMUNITY OF SUPPORT

- ▲ Who are the key players helping to improve diabetes outcomes?
- ▲ What are some current efforts that are making the difference in outcomes?

▲ A PROGRAM OF PREVENTION

- ▲ What is the deeper meaning of "Diabetes – Control is Prevention?"
- ▲ What can we do to solve the problems caused by diabetes?
- ▲ How can we work together to solve the problems?

The CDC will be making video tapes of an edited version of the program available to state Diabetes Control Programs. If you are interested in borrowing the tape, contact Betsy Solan, New Jersey Department of Health and Senior Services, Diabetes Control Program at (609) 984-1343. ■

diabetes mellitus in pediatrics

MANAGEMENT GUIDELINES

Diabetes mellitus is a chronic disease of inadequate or inappropriate fuel metabolism, especially involving glucose utilization. It may be due to insulin deficiency (type 1) or due to the deficient insulin action with adequate or high insulin levels (type 2). The vast majority of pediatric aged patients who have diabetes mellitus have type 1. This is due to autoimmune destruction of the insulin producing beta cells of the pancreas. For purpose of this article, the term "diabetes" will refer only to type 1 diabetes mellitus.

Table 1a

DIABETES PEDIATRIC PERFORMANCE MEASURES (< 18 YEARS OF AGE)

FREQUENCY OF VISITS	every three months
HEIGHT & WEIGHT, INCLUDE PERCENTILE	every visit
CARDIOVASCULAR ASSESSMENT	Blood Pressure every visit
GROWTH CURVE	every visit
EYE EXAMINATION	baseline AND prepuberty - every 2 years after 5 years from diagnosis onset of puberty or 13 years of age — yearly
LIPID PROFILE	random cholesterol/triglycerides after initial diagnosis if abnormal, then fasting. yearly if abnormal, every 5 years if normal
HEMOGLOBIN A_{1C}	every three months
U/A FOR MICROALBUMIN	yearly after puberty or first 5 years of diagnosis
THYROID FUNCTION (TSH)	initially and then as indicated
EDUCATION APPROPRIATE TO DEVELOPMENTAL STAGE: STD, PRE-PREGNANCY/ PREGNANCY COUNSELING; SMOKING AND SUBSTANCE ABUSE	ongoing

It is estimated that between 1:300 children and 1:600 children have diabetes in the United States. The incidence of diabetes varies worldwide between rates as low as less than one in Japan, to as high as thirty new cases in Finland per hundred thousand population per year. In the United States, the incidence rates approximate 14-16 new cases per hundred thousand population per year. Most new cases of diabetes are diagnosed in late fall and winter to early spring months. Diabetes can occur at any age from early infancy to adulthood. However, many people with diabetes become aware of their diagnosis in the early puberty years (between 11-13 years). It is therefore crucial that primary health care providers consider the diagnosis in infants, children, adolescents, and young adults. The presenting signs and symptoms of diabetes include: polyuria, polydypsia, nocturia, polyphagia, and weight loss. These symptoms usually occur anywhere from a few days to several weeks, although recent evidence suggests that the process of beta cell destruction may last for years before clinically overt diabetes becomes evident. The diagnosis may not be easily apparent in young infants in whom episodes of diarrhea, vomiting, with or without decreased appetite, or respiratory difficulties are frequently ascribed to intercurrent gastro-intestinal or pulmonary illnesses. In fact, these symptoms may represent the development of diabetic ketoacidosis. Similarly, diabetes has gone undiagnosed in adolescence whose weight loss was masked by oversized fashion outfits or ascribed to dietary manipulations in an effort to achieve "ideal body weights".

Once the diagnosis of diabetes is made, it is crucial that the patient and his or her family have access to a properly trained pediatric diabetes health care team that includes a pediatric nurse educator, nutritionist, social worker, psychologist, podiatrist, exercise physiologist, and endocrinologist. Together with a primary health care provider, this team can help the patient and the family cope with the diagnosis of a life-long disease. The education the patient and the family receive at the time of diagnosis will be of paramount importance in the long-term successful management of diabetes. It is important that both short and long-term goals in the management of diabetes be enunciated clearly at the onset and that they are child and family specific. The goals include the avoidance of the acute signs and symptoms of hypoglycemia and hyperglycemia, as well as the long-term consequences of repeated episodes of hypoglycemia and hyperglycemia. The child should be able to grow and develop normally, physically, psycho-socially, and emotionally. To this end, the health care team and family should agree upon clear cut and achievable specific management target goals. These goals should include attempts at achieving the best glycemic control possible, while at the same time avoiding hypoglycemia. In children less than seven years of age,

the avoidance of severe and repeated episodes of hypoglycemia outweighs the concern about the avoidance of high blood glucose. The reason for this is that severe and/or repeated episodes of hypoglycemia during this time period may have serious adverse effects on children's neurological and psychological development. The findings of the recently published Diabetes Complications and Control Trial (DCCT) were discussed in the previous issue of this Diabetes Newsletter. It is important to remember that the DCCT study only included children 13 years of age and older. It was not designed to answer questions regarding glycemic control in young children. The two most important adverse effects in attempting to achieve very tight blood glucose control include severe hypoglycemia, particularly not advisable for young children, and excessive weight gain which is undesirable for adolescents, especially adolescent girls.

The New Jersey Diabetes Council has identified the Diabetes Pediatric Performance Measures in this article as the minimally acceptable standards of care for the primary care providers. These guidelines address pediatrics below the age of 18 years. (See Tables 1a and 1b)

management guidelines

Optimal management of children with diabetes and their families involves close cooperation between the primary health care providers and the pediatric diabetes specialist team. At diagnosis, families and patients are instructed in home blood glucose monitoring including finger-stick glucose measurements at least 2-4 times daily, proper record keeping even if using meters that have memory, as well as guidelines for the recognition and treatment for hypoglycemia, hyperglycemia, and what to do on sick days.

All youths with diabetes require insulin administration for management. Most children require insulin at least 2-3 times daily. Usually a combination of rapid acting insulin of either regular or Humalog (lyspro) insulin, and an intermediate acting insulin is given in the morning and before dinner. As more intensive therapy is recommended, many children, especially adolescents are being switched to three daily insulin injections, with only rapid acting insulin before dinner and intermediate acting insulin at bedtime. Other treatment regimens include the use of long acting insulins (ultra lente) supplemented by rapid acting insulins before mealtimes. Recently, adolescents and young adults with diabetes have increased their use of pen devices containing cartridges of insulin that can be easily and inconspicuously carried, as well as insulin pumps.

School personnel need to be involved and apprised of the specific management guidelines for the student with diabetes. A minimal recommendation for the care of the youth with diabetes is included in Tables 1 (a & b). We believe that the visit to the endocrinologist should occur at least 3-4 times yearly and communication with the pediatric endocrinology team should be encouraged by way of regular telephone calls, faxes, etc. The increased communication between the health care team and patients was shown to be the key to the success of the intensively treated patients in the DCCT. Routine laboratory management should include (see table) Hemoglobin A_{1C}, thyroid function tests, and kidney function tests. Ophthalmologic evaluations are also routine. As mentioned, specific management guidelines need to be individualized according to the patient, the patient's age, and the family circumstances.

The primary health care provider is key to the initial recognition of diabetes in infants, children, and adolescents, and remains key to the successful management efforts of the patients and the pediatric diabetes specialty care team.

(Robert Rapaport, MD, Director of Pediatric Endocrinology, Children's Hospital of New Jersey and Joslin Center Youth Division at St. Barnabas Medical Center). ■

Table 1b

APPROPRIATE REFERRALS TO SPECIALISTS

NUTRITIONAL COUNSELING	Registered Dietitian at diagnosis, yearly and as needed
REFERRAL FOR PATIENT SELF-MANAGEMENT EDUCATION: RN, CDE	at diagnosis, yearly and as needed
PEDIATRIC ENDOCRINOLOGIST	at diagnosis and every three months
OPHTHALMOLOGIST	baseline AND prepuberty — every 2 years after 5 years from diagnosis onset of puberty or 13 years of age — yearly
DIABETES STRESS COUNSELING TO CHILD/FAMILY	at diagnosis and as needed
PODIATRY CONSULT	as needed
PEDIATRIC RENAL SPECIALIST	as needed or when microalbuminuria is positive 2 out of 3 samples
MATERNAL FETAL SPECIALIST	during pregnancy

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1. Aspects of the Etiology, Prediction and Prevention of Insulin-Dependent Diabetes Mellitus in Childhood. M. A. Sparling in Pediatric Clinics of North America. 44:2, 4/97 P 269-284.
2. Rapaport, R., Sills, I. - Implications of the DCCT for children and Adolescents with IDDM - N.J. Med. 91:227-8, 1994.

the certified diabetes educator: add one to your team!

What exactly is a Certified Diabetes Educator (CDE) and does a CDE have a role in your practice? The Diabetes Control and Complications Trial (DCCT) documented that blood glucose control leads to less diabetes related complications. The American Diabetes Association (ADA) standards of medical care call for actions on the part of the physician when diabetes control is not meeting the standards. The ADA has acknowledged that patient education is imperative to diabetes management. A CDE is the key to this education.

Diabetes is a chronic disease that places considerable stress on the individual and their family. Diabetes calls for numerous self care adjustments and modifications to one's lifestyle. Since you are asking individuals to change years of routines and habits, it will take time. It often takes hours of individualized instruction for a patient to fully understand and make the necessary changes for diabetes control. Remember, a person only retains 10% of what they read and 20% of what they hear, but the person who is involved in active learning will recollect 90% of the information. Diabetes education involves providing the skills and information necessary for the patient to assume the responsibility for their diabetes care. The CDE helps the patients set goals and evaluate their own progress towards independent care.

A CDE can help your patients learn about diabetes, and enhance their ability to manage and prevent the complications of their disease. A CDE is defined as a health care professional who has mastered the core of knowledge and skill in the biological and social sciences, communication and counseling, and education; and who has experience in the care of patients with diabetes. CDEs include but are not limited to: physicians, registered nurses, registered dietitians, pharmacists, social workers, podiatrists and exercise physiologists. Each professional is unique in his background, but each has a core understanding of diabetes. The CDE has spent over 2000 hours in individualized diabetes care and has passed the national certification exam. To assure a high standard of expertise, the CDE must retake the exam every five years.

Your patients need to know how to monitor their own blood glucose levels, how to take their medications as prescribed, and how to check their feet on a daily basis. In addition, they need to understand what diabetes is and the lifestyle changes they need to make in order to prevent the complications of the disease. As a primary care provider, you are being faced daily with a need to provide quality patient care and education with limited time to meet patients' growing needs. As part of your diabetes package, a CDE can help you offer quality care for your patients with diabetes.

When you refer your patient to a CDE you should expect to develop a relationship with that professional. You are developing a team which includes, but is not limited to, the patient, the physician and the educator, united in the goal of improving blood glucose control and diabetes management. The CDE to whom you refer should be able to discuss with your patients the pathophysiology of diabetes, the nutritional management of diabetes, pharmacological interventions, and benefits of exercise and activity. Most importantly, the educator will be able to show your patients how the interaction between all aspects of lifestyle modifications affects their diabetes control. The CDE should be able to teach self monitoring of blood glucose levels and work with you and your patients in setting target goals and in correlating their glucose levels, their medication, activity and nutrition. The CDE will work with your patient in the prevention and management of acute and chronic complications, psychosocial adjustment to diabetes, stress management, and the incorporating of individual circumstances, cultural differences, and learning style. Overall, the CDE will assess your patient for educational needs, plan a teaching- learning process and implement the education plan, document the process, evaluate the process and confer back with you on the patient progress for the development of individualized goals.

Persons should be referred to a CDE when they are newly diagnosed, new to insulin, for medical nutrition therapy, changes in therapy, for activity guidelines, monitoring of their blood glucose levels, when experiencing hyper or hypoglycemia, for sick day management, foot and skin care instruction, and pre and post conception counseling. After the initial and follow up consults, the person ideally should see their educator once a year for evaluation.

How can you link up with a CDE in your area? Places for you to find local CDEs are the ADA (1-800-DIABETES) for locally accredited programs, The American Association of Diabetes Educators (1-800-832-6874), the American Dietetic Association (1-800-745-0775), and possibly your local hospital. (Mary Johnson, RD, MS, CDE, Director of Nutrition, Joslin Center for Diabetes at Saint Barnabas, Princeton and Dorothy Caputo, MA, RNC, CNA, CDE, Diabetes Program Development Specialist, UMDNJ-RWJMS). ■

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Diabetes Newsletter Test Questions
ORIGINAL RELEASE: February, 1998
EXPIRATION: June, 1999

For each question, fill in the **one** best answer on the answer sheet (page 8).

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test questionnaire

1. The incidence of type 1 diabetes occurring in children in the United States is:
   a. 1:2000
   b. 1:1000
   c. 1:600
   d. 1:100

2. Most new cases of type I diabetes are:
   a. diagnosed in late fall and winter to early spring months
   b. diagnosed in the early pubertal years (between 11 -13)
   c. easily recognizable in young infants with symptoms of diarrhea and vomiting
   d. All of the above
   e. A and B

3. Patients with type 1 diabetes require insulin treatment:
   a. often
   b. sometimes
   c. never
   d. always

4. The management goal of young people with type 1 diabetes mellitus is:
   a. achieving near normal glycemia
   b. avoidance of symptoms of hypoglycemia
   c. avoidance of symptoms of hyperglycemia
   d. need to be individualized according to the patient based on his/her age and family
   e. B and C

5. Hemoglobin A_{1C} should be obtained in the course of the management of children with type 1 diabetes:
   a. yearly
   b. every 6 months
   c. every 3 months
   d. monthly

6. The Diabetes Control and Complications Trial:
   a. was designed for children and adults
   b. includes only adults
   c. includes a small number of adolescents
   d. was designed for patients with type 2 diabetes

7. The baseline value of the fasting plasma glucose for the diagnosis of diabetes mellitus as defined by the Expert Commitee on the Diagnosis and Classification of Diabetes Mellitus presented in Boston in June 1997 is:
   a. 140 mg/dl
   b. 105 mg/dl
   c. 126 mg/dl

8. The recommendation of this same Expert Committee from the ADA is that the medical community begin testing for diabetes mellitus in:
   a. all persons aged 45 or above at 3 year intervals
   b. persons < age 45 having first degree relatives with diabetes mellitus
   c. high risk ethnic groups (African, Hispanic, Native and Asian Americans) below age 45
   d. all of the above

9. A CDE is a health care professional who has passsed a national exam in core knowledge of diabetes care. CDEs include, but not limited to:
   a. Registered Nurses
   b. Registered Dietitians
   c. Physicians
   d. Social Workers
   e. All of the above

10. It is important to refer your patients with diabetes to a CDE:
    a. When they are newly diagnosed
    b. once a year
    c. only when receiving insulin
    d. All of the above
    e. A and B

For additional copies of newsletter, comments and inquiries, contact DOROTHY CAPUTO, MA, RNC, CNA, CDE, *Editor and Project Coordinator at (732) 235-7430 or e-mail caputoda@umdnj.edu*
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Diabetes Newsletter Answer Sheet
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Expiration: June 1999

diabetes NEWSLETTER

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questionnaire answer sheet

1. Read the Newsletter carefully.

2. The questions are designed to provide a useful link between each submission and your everyday practice. Read each question, choose the correct answer so that they can be compared with the correct answers that will be sent to you at a later date.

3. Type your full name, address, and Social Security number in the space provided.

4. Use the enclosed postage -paid envelope to return your completed test or send the completed answer sheet to:

UMDNJ
Center for Continuing Education
30 Bergen Street
Newark, NJ 07107-9816

(973) 972-4267

Outside (973) Area Code
1(800) 227-4852

5. Your answers will be graded, and you will be advised that you have passed (or failed). An answer sheet containing all correct answers will be mailed to you. Review the parts of the newsletter addressing any questions you have missed and read the materials suggested in the listed references.

6. A minimum score of 70% correct must be obtained in order for credit (AMA/PRA category 1, 1.0 credit hours) to be awarded.

Evaluation Number

Shade circle like this: ●
NOT like this: ⊗ ✓

1	A	B	C	D		6	A	B	C	D
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diabetes
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	Y	N
Was this publication balanced, free of commercial bias?	○	○
Did this activity meet the stated objectives?	○	○

What topics would you like addressed in future publications?

Evaluation Number

objectives

Upon completion of this activity, the participant should be able to:

1. Discuss the appropriate management of pediatric patients with diabetes
2. Recognize the role the health care team plays in the treatment of pediatric patients with diabetes
3. Define the minimum standards of care for pediatric patients with diabetes
4. Identify the conclusions recommended by the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus of the ADA
5. Discuss the role of the CDE in the education of the patient with diabetes
6. Identify the newly defined blood glucose values diagnostic of diabetes mellitus

participating organizations

First Option, University Health Plan, CAMcare, Eric B. Chandler Health Center, Jersey City Family Health Center, Newark Community Health Center, North Hudson Community Action Health Center, Plainfield Neighborhood Health Center and VNA of Central Jersey Community Health Center.

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reviewed by

This newsletter was reviewed for relevance, accuracy of content and time required for participation by Louis Amorosa, MD, Steven H. Schneider, MD, Joanne D. Moore, RN, CDE, Javier Aisenberg, MD, CDE, Ronnie Davidson, Ed.D, Elizabeth B. Congdon RN, MA, Betsy Solan RN, MPH, Dorothy Caputo, MA, RNC, CNA, CDE, and the New Jersey Diabetes Council. The Diabetes Pediatric Performance Measures were reviewed for relevance and accuracy of content by all of the above and Max Salas, MD, Harold Starkman, MD, Robert Rapaport, MD, Arthur Krosnick, MD and Karen Ingram, MD. This newsletter was designed by UMDNJ-RWJMS Media Resources Department.

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UMDNJ-Center for Continuing Education is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

category credits

The University of Medicine and Dentistry of New Jersey - Center for Continuing Education designates this educational activity for a maximum of 1.0 credit hour in category 1 towards the American Medical Association / Physician's Recognition Award, provided the post-activity test is completed with a minimum passing score of 70%.

This CME activity was prepared in accordance with ACCME Essentials. Credit for this CME Test is available until June 1999. After this date, physicians may self-designate category 2 for this activity.

Correct answers will be returned with your scored test and the CME credit letter within 30 days of receipt of your answer sheet.

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The target audience for this enduring material are those primary care providers who manage adult and pediatric patients with diabetes.

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